Can We Work Toward Medicine to Minimize Disruption?

In their update of progress toward minimally disruptive medicine (MDM), Boehmer et al1 take us on an epistemological excursion through working with patients living with multimorbidity. Minimally disruptive medicine requires a balance of treatment burden and patient capacity. “Intellectually” we know our clinical recommendations of lifestyle changes and tasks cannot be easy.2 As health care professionals (HCPs), we support better outcomes and lives for the people we treat, but we may not define those outcomes from our patients’ perspective and their capabilities or capacities.

In explicating MDM, Boehmer et al have outlined the conceptual frameworks that MDM embodies. The tables included with the article fortunately define and explain terms such as patient biography, cognitive participation, and maximizing collective competence, which few HCPs use or understand.3 The conclusion that we have made limited progress toward MDM is not surprising.

But we have addressed MDM in acute care. Acknowledging that people have limited capacity to obtain acute care during “office hours,” we have developed urgent care clinics, extended hours, and limited care clinics in storefronts and expanded HCP-developed Internet self-care guidance. For many HCPs, these do support fewer disruptions to our lives and suggest that we understand at least the general concept of MDM.

Now we need to turn this focus to multimorbidity care. A first step may be to consider the name MDM. Busy clinicians often judge a package by its title, and MDM is hard to visualize for a patient with multimorbidity. How can all of the important treatment and lifestyle changes be “minimally” disruptive? If it was so minimal, would it not be easier to accomplish? To catch the attention of busy HCPs, maybe a name change to medicine to minimize disruption (MMD) suggests a more feasible goal with a better chance of obtaining clinicians’ buy-in to entice them to the “table.”

To implement MMD, HCPs need to understand what we ask patients and their families to understand and to implement, labeled treatment burden. How often do we take the time to “teach back”—asking the patient and family to report back what they have been asked to do for their diabetes or chronic obstructive pulmonary disease or obstructive sleep apnea and why. The results are often enlightening and unexpected.5 The ICAN tool (https://minimallydisruptivemedicine.org/2015/10/05/introducing-the-new-ican-tool/) may facilitate this with the simple question, What have your doctors or clinic asked you to do to take care of your health? Do they help or are they a burden? This is unlikely to be completed at a single visit. Generalists’ care is designed to be longitudinal, allowing an accumulation of knowledge about the patient over time. Unfortunately, stepwise collection of a patient biography by use of current electronic medical or health record (EMR) systems is not easy.6

The EMRs often have limited opportunities to efficiently and systematically record data on the patient’s and family’s role in MMD. Where do we put assessment of coherence, patient goals and life situation with treatment requirements; cognitive participation, documenting discussion of teamwork and members’ responsibilities; biography, who the person is and what diseases or conditions mean to the person; or resources or environment, food access, available time? Visit notes limited to checklists are the antithesis of this type of information collection. “Copy and paste” from previous...
visit data is often used to meet billing requirements and is supported by EMR design. Conversely, building a longitudinal picture of the patient’s and family’s perceived burden and capacity is not clearly supported. Having a place to record the responses to a tool like ICAN that are supplemented in future visits needs to be available without large EMR development charges. Perhaps if there were a single International Classification of Diseases, Tenth Revision code for “multimorbidity” with linked billing codes, EMRs would be amended to support collecting data on matching treatment burden and patient capacity.

The description of Bob’s case and need for MMD resonates with HCPs and further illustrates how an EMR might support multimorbidity care. Like Bob, many people with multimorbidity use continuous positive airway pressure (CPAP) or other durable medical equipment. But finding details on prescribed durable medical equipment in the EMR can be difficult and time-consuming. Having a specific place for listing this equipment, like CPAP or home oxygen or glucose monitors, at the bottom of the medication list might have facilitated awareness that Bob’s CPAP was out of date. Listing these prescribed resources with medications could facilitate their addition to the patient’s medication list. Awareness that Bob’s CPAP was out of date might have facilitated his purchase of a new one.

So far, this is only half of the burden/capacity balance equation. As noted by the authors, there are no validated tools to assess the patient’s or family’s capacity. That leaves HCPs trying to translate elements of the conceptual framework on the patient’s biography or environment or resources into understanding “capacity.” It is not clear how to move toward identifying strategies, resources, and help to develop or to support the existing capacity. I do not need more conceptual frameworks but rather specific steps to move to action—a need the authors also identify.

The goals of MDM or MMD, to better fit with my HCP vocabulary, must be addressed as our population ages and develops more comorbidity and as we increasingly include the patient and family in our health care teams. We still have many potential barriers to overcome, including clinicians’, health systems’, and payers’ understanding and buy-in and potential updates to our EMR and International Classification of Diseases, Tenth Revision and billing codes, to acknowledge the work of MMD and to support longitudinal biographic data that can be translated to actions in clinical care.

Barbara P. Yawn, MD, MSc, FAAFP
Department of Family and Community Health
University of Minnesota
Minneapolis, MN

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Correspondence: Address to Barbara P. Yawn, MD, MSc, FAAFP, Department of Family and Community Health, University of Minnesota, 1963 112th Circle NE, Blaine, MN 55449 (Byawn47@gmail.com).

REFERENCES


